## 8.B Medicare: Enrollment, Utilization, & Reimbursement

Table 8.B6.—Hospital Insurance: Number of bills approved for payment and amount reimbursed, by type of benefit and type of beneficiary, 1966-97

[In thousands, Includes only approved bills recorded in the Health Care Financing Administration records before March 31, 1998]

	Total <sup>1</sup>		Inpatient hospital <sup>2</sup>		Home health		Skilled-nursing facilities <sup>3</sup>	
Year approved	Number	Amount reimbursed	Number	Amount reimbursed	Number	Amount reimbursed	Number	Amount reimbursed
	Total							
1966 1970 1975 1980	1,979 7,512 10,318 13,866	\$824,367 4,855,161 10,414,195 23,200,897	1,866 6,313 8,687 11,088	\$821,362 4,578,080 10,006,206 22,367,454	34 571 1,07 2,266	\$2,113 46,896 145,631 473,805	627 553 512	\$230,183 262,358 359,638
1985	15,615	37,533,351	10,352	35,414,544	4,747	1,656,411	515	462,396
	15,527	41,076,274	10,342	38,646,919	4,632	1,796,454	481	553,036
	15,608	43,507,272	10,283	40,736,827	4,608	1,889,195	597	753,494
	16,628	49,711,315	10,083	44,673,409	4,962	2,218,971	1,406	2,595,128
1990	18,601	54,946,122	10,563	49,074,386	6,420	3,323,471	1,405	2,232,412
	20,878	62,526,234	10,832	54,769,237	8,366	5,036,914	1,375	2,243,293
	24,138	76,911,288	11,548	65,798,975	10,436	7,093,126	1,638	3,135,228
	26,678	82,575,833	11,279	67,569,095	12,793	9,571,019	1,919	4,250,224
	29,828	91,101,325	11,662	71,682,678	15,037	12,142,306	2,255	5,691,371
1995	33,253	102,180,586	12,064	77,606,018	17,511	15,118,757	2,664	7,541,057
1996	34,567	108,638,992	11,979	80,729,152	18,513	16,428,529	3,008	9,466,043
1997	35,382	114,506,765	12,141	84,062,258	18,766	16,884,745	3,308	11,408,861
	Persons aged 65 or older <sup>4</sup>							
1973	8,080	\$6,550,708	6,980	\$6,297,814	624	\$60,549	476	\$192,345
1975	9,389	9,429,866	7,844	9,041,321	1,009	135,687	536	252,859
1980	12,287	20,357,667	9,705	19,580,817	2,097	436,589	485	340,250
1985	14,063	33,325,618	9,160	31,348,094	4,404	1,530,937	499	446,587
	13,999	36,627,064	9,159	34,355,504	4,307	1,664,255	465	532,334
	14,128	38,938,452	9,141	36,336,949	4,296	1,755,696	577	724,821
	15,039	44,200,304	8,901	39,460,554	4,624	2,059,947	1,347	2,468,838
1990	16,886	48,946,318	9,347	43,426,173	5,988	3,090,502	1,349	2,131,716
	18,989	55,705,195	9,565	48,416,192	7,810	4,686,633	1,325	2,152,832
	21,931	68,396,493	10,129	57,957,977	9,736	6,593,055	1,579	3,012,800
	24,223	73,211,836	9,830	59,165,104	11,898	8,851,257	1,849	4,079,911
	27,007	80,396,686	10,092	62,255,035	13,926	11,205,712	2,166	5,446,473
1995	30,005	89,756,403	10,363	66,903,360	16,140	13,869,578	2,551	7,191,881
1996	31,065	95,057,882	10,204	69,169,979	16,987	14,999,499	2,872	9,003,616
1997	31,784	100,196,496	10,348	71,974,567	17,187	15,368,289	3,151	10,834,236
	Disabled persons <sup>5</sup>							
1973	215	\$173,178	206	\$170,850	6	\$692	4	\$1,637
	929	984,329	843	964,885	69	9,944	17	9,499
	1,545	2,773,750	1,357	2,722,587	168	37,199	18	13,965
	1,772	4,174,624	1,407	4,052,658	346	105,995	18	15,971
	1,612	4,005,159	1,232	3,868,195	363	121,589	17	15,375
1985	1,552	4,207,733	1,192	4,066,450	343	125,474	16	15,809
	1,528	4,449,211	1,183	4,291,415	325	132,199	16	20,702
	1,480	4,568,819	1,142	4,399,878	312	133,498	20	28,673
	1,589	5,511,011	1,182	5,212,855	338	159,025	59	126,290
1990	1,715	5,999,804	1,216	5,648,213	431	232,969	56	100,696
1991	1,889	6,821,039	1,267	6,353,044	555	350,282	50	90,460
1992	2,207	8,514,795	1,419	7,840,999	701	500,071	59	122,428
1993	2,455	9,363,998	1,449	8,403,991	895	719,762	71	170,313
1994	2,822	10,704,639	1,570	9,427,643	1,111	936,594	89	244,898
1995	3,248	12,424,183	1,701	10,702,659	1,371	1,249,179	113	349,176
1996	3,502	13,581,110	1,775	11,559,173	1,526	1,429,029	136	462,427
1997	3,598	14,310,270	1,794	12,087,691	1,579	1,516,456	157	574,625

prospective payment is considered payment in full; hospitals are prohibited from charging beneficiaries more than the statutory deductible and coinsurance. Additional payments, determined by nondiagnostic criteria, are made to hospitals by the program for various "pass-through" costs and additional adjustments. These additional payments are not included in the inpatient hospital billing amounts reimbursed shown in this table.

<sup>&</sup>lt;sup>1</sup> Included in total but not shown separately are data on approved bills for outpatient diagnostic services rendered before Apr. 1, 1968. Beginning in April 1968, outpatient diagnostic services, formerly covered under Hospital Insurance, are covered under Supplementary Medical Insurance. Data on approved bills for hospice services are included in total after 1985.

<sup>2</sup> The Social Security Amendments of 1983 (P.L. 98-21) replace (for most hospitals) the retrospective cost reimbursement system and the cost-per-case limits and rate of increase ceiling created by the Tax Equity and Fiscal Responsibility Act of 1982. Effective with hospital cost-reporting periods beginning on or after Oct. 1, 1983, Medicare payments for inpatient operating costs are to be based on a fixed amount, determined in advance, for each case, according to one based on a fixed amount, determined in advance, for each case, according to one of 495 diagnosis related groups (DRGs) into which a case is classified. The

<sup>&</sup>lt;sup>3</sup> Coverage began Jan. 1, 1967. Benefit payments shown for 1985 are incomplete due to billing lags.

<sup>4</sup> Beginning Oct. 1, 1978, includes a relatively small number of persons entitled to benefits solely because of end-stage renal disease.

<sup>&</sup>lt;sup>5</sup> Includes a relatively small number of persons under age 65 entitled to benefits solely because of end-stage renal disease.